Disaster Medical Care

The Objectives of the A.M.A. Committee and the Organization Of a County Society Program

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THE GUIDING UNIT and the spokesman in the work of the American Medical Association in disaster medicine is the Council on National Security. The Council on National Security is an appointed council charged with the study and planning of all measures relative to medical manpower, both military and civilian, that is available for immediate and reserve use in the event of large scale local disaster or in the event of total warfare. Also included in this category are all the health services furnishing support to the effective operation of medical personnel.

For purposes of maneuverability and division of labor, the Council has two working committees, namely, the Committee on Military Affairs (nine members) and the Committee on Disaster Medical Care (eight members). We will discuss only the Committee on Disaster Medical Care. The members of this committee were selected without regard to geographical representation. Selection was on the basis of outstanding local work in medical Civil Defense, as related to preparations for total warfare.

Objectives of the committee are to promote medical disaster planning from the national level by:

1. Informing the individual physician of the latest developments of medical disaster planning and care, and by disseminating such information by correspondence, medical publication, assembled meeting and the lay press.

2. Assisting state and county medical societies with medical disaster planning and care, when so requested.

3. Continuing and expanding present cooperation and liaison with appropriate Federal Government agencies and other national associations relative to national level planning; and

4. By informing the general public of the development and progress of medical disaster planning and care, in order that there be instilled in the population a sense of medical security in event of large scale local disaster, and a sense of possible survival care in event of total disaster.

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The functions of the committee have steadily increased from year to year, as the problems of disaster medicine have made themselves more apparent. Current functions are as follows:

1. Since 1949, the committee has sponsored the Annual County Medical Societies Conference on Civil Defense. This is held as a two-day conference, usually on the first weekend of November in Chicago. Subjects are presented by national authorities in their respective fields, and range from the latest information on fallout patterns, to more down-to-earth everyday reviews of large scale local disasters from man-made or natural causes. Workshop discussions of the final results of trial exercises contribute much to the knowledge of the participants. This year the tenth annual conference resulted in a record attendance of 270 officials of state and county medical societies and other medical and allied personnel active in Civil Defense. Thirty-three states and Canada were represented.

2. Since 1953 the committee has sponsored the annual one-day Conference on Civil Defense of the American Medical Association at the annual meeting of A.M.A. This year's meeting had 300 in attendance, representing some 40 states.

3. Since 1950 the committee has sponsored effective liaison with all federal agencies. Examples of the results of this liaison were (a) an endorsement of the post of Assistant Director of Health in the Office of Civil Defense Mobilization (OCDM), which gave effective voice to medical policy; and (b) an endorsement of the plan of the Department of Health, Education, and Welfare to use the established facilities of the USPHS to implement medical disaster planning for OCDM on a national basis.

4. In 1957, on contract with the then FCDA, Federal Civil Defense Administration, the committee produced, after much research and development, a national plan for disaster medical care in the event of total warfare. This plan was completed in April of 1959.[4]

5. The committee participates in the joint committee evaluation and study of the program in the medical schools, termed Medical Education for National Defense, which supplants the former Medical ROTC. This course indoctrinates the medical student

during his class days in the principles of disaster medicine.

6. The *Civil Defense Review* is published by the committee. It has a circulation of 2,000. Compiled in it are all current and pertinent information relative to medical disaster planning and events in the United States.

7. Also the committee holds biannual meetings with the chairmen of state medical society disaster committees and the respective state medical disaster directors. These meetings are held in the representative OCDM regions. Through these most important meetings the committee seeks to determine the particular needs and problems of each state medical disaster committee.

As your western representative on this committee, I will appreciate your views on any problem of medical disaster planning that you feel can be beneficial to this entire program.

As to the organization of a county medical society for medical care in event of disaster, I must emphasize that there can be no effective disaster medical care without the participation in and the planning for such care by practicing physicians. The work of planning and the direction of such care must be the duty of the physicians' representative body—namely, the county medical society.

The organization of a county medical society for disaster medical care must begin with the appointment of a committee on disaster medical care. Physicians selected for this committee should have either executive organizational ability, a background in traumatic medicine, or field combat experience in World War II or Korea. To effect an adequate program, the committee should consider the following:

1. Objective:

a. To provide effective medical and health services planning and care for the population area served by the society in the event of large scale local disaster.

b. To coordinate such existent planning with peripheral county medical societies for mutual aid and care in the event of total disaster.

2. Organization:

Basic planning should be divided into two components; namely,

a. Effective means of medical care of casualties from disaster site to hospital center. (Existent municipal systems may be found to be adequate; but if there is no adequate plan, one must be organized.[1])

b. The designation and establishment of a command post at the medical society headquarters or the county Civil Defense control center, whichever is most feasible. The command post, which must have good liaison with the resident Civil Defense coordinator of the county, functions as the coordinator's medical staff consultant during a large scale local disaster. Specifically the following duties may be assigned:[3]

1. Furnish additional medical nursing and ancillary medical personnel to disaster sites or hospitals on request.

2. Have knowledge of current bed census throughout the county and shift casualty loads from disaster sites on request of disaster site medical officers or hospitals.

3. Assist the Civil Defense coordinator of the county in the event of overload of entire county bed availability by channeling requests to peripheral county medical societies for help in providing out-of-county available beds.

4. Assist the Civil Defense coordinator of the county in getting authorization from the regional office of the California Disaster office for indigenous use of stored Civil Defense hospital units if such seems feasible.

5. Fulfill requests for whole blood in accordance with the capacity of the local blood bank.

6. Initiate requests to the regional office of the California Disaster Office for narcotics and other items if the needs cannot be met within the county.

7. Recommend procedures as to matters involving mortuary services and facilities and public health when such problems cannot be solved at the disaster site or local level.

Personnel of the command post should be composed of coordinators for each of the following disciplines, with three or more alternates: Medical, nursing, dental, veterinary medical, pharmacy, mortician-coroner, blood bank.

3. Hospitals:

The county society through its Committee on Disaster Medical Care will request the chief of staff of each hospital to appoint a committee on disaster medical care. The first function of this committee will be to write a hospital disaster[5] plan compatible with the facilities and personnel existent in the hospital. This plan should include three basic phases:

Phase One—Hospital disaster planning for disaster within the hospital due to fire, explosion, earthquake damage, epidemic, etc., defining provisions for care of all persons in the hospital.

Phase Two—Hospital disaster planning for large scale local disaster in which the hospital functions to receive large number of casualties from the community or area it serves.

Phase Three—Hospital disaster planning for total disaster due to widespread national destructive

forces in which the hospital may either evacuate personnel and regroup in another area before disaster strikes or, if the hospital survives the disastrous force, be able to mobilize its remaining facilities and remain functional.

4. Resources:

The county medical society Committee on Disaster Medical Care, through its command post personnel and planning, will be cognizant of all medical resources within the county society's jurisdictional area. Such resources defined should be:[1]

a. The census of all beds, hospital and convalescent; also, available indigenous Civil Defense emergency hospital stored units, and buildings suitable for conversion for added bed space.

b. Census of ancillary medical personnel, especially nurses, dentists, veterinarians, pharmacists, laboratory technicians, morticians and coroners and deputy coroners.

c. Rough inventory figures of drugs, vaccines, dressings and intravenous fluids of the average hospital in the area, as well as the same items in the nearest wholesale drug firms.

d. The availability of food, water, auxiliary power, heat and light, as they pertain to medical care facilities.

5. Liaison with City and County Government:

There can be no effective community or county medical disaster planning and care without full cooperation and agreement between medical society disaster medical care committees and city and county Civil Defense coordinators. The county medical society, in its planning, must seek to provide the best immediate and thorough medical support and care to the community and county Civil Defense effort in time of disaster.

In areas having adjacent military installations, the representative surgeon should be requested to participate in medical disaster planning, in order that in an extreme disaster state, the available facilities of the military installation may be easily integrated with civilian resources and confusion avoided.

The California Disaster Office medical personnel as well as the regional USPHS surgeon (OCDM) should be informed of any completed planning, and the medical society committee should call upon these offices for any advice it may need.

6. Communications:

Organizational structure and function will collapse without communication. All available types of communication must be maintained, if possible, between the county society command post, the county Civil Defense control center, the hospitals in the area and the disaster site. Whenever possible a survey should be made in the county area to determine the kind of short-wave radio equipment best suited for use. Installation of such equipment at all key sites should be carried out and provision made for operation of it by resident personnel familiar with medical terms and technology. (The A.M.A. has made representation to the Federal Communications Commission for medical communication on 13 frequencies in the 152-162 megacycle band and four frequencies in the 42-52 megacycle band.)

7. Test Exercises:

The county medical society Disaster Medical Care Committee should sponsor annually a test exercise involving the actual functions of all casualty care from disaster site to hospital center. This function has no substitute in pointing out weakness in planning, and it also serves as a test of the adequacy of any improvements that may have been introduced.[2]

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